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June 5, 2002

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Dear John:

I am writing about a matter of the utmost importance -- it may, indeed, even constitute a crisis -- involving the future status (destiny) of Baylor College of Medicine and The Methodist Hospital. It concerns the affiliation of the two institutions, with critical emphasis on their defining structure, governance, and faculty-staff integration. Since I played a primary role in establishing the original affiliation (in an environment not entirely salutary, sometimes even hostile), I have had almost a half century of experience that would have been far more satisfying absent the obligatory compromises in academic principle. As a result, I have developed some strong convictions, which have long been undisputed in medical academic circles.

In some respects, this matter exemplifies *déjà vu*. In May, 1948, after my visit to Houston and the invitation to consider the Chairmanship of the Department of Surgery at Baylor University College of Medicine, I wrote Dr. Warren Brown, then Associate Dean, as follows: "The most important and least satisfactory arrangement at the present time is the provision for clinical facilities under the full management of the University. Until some satisfactory solution for the problem is developed, the

clinical departments of the Center, and particularly the stimulus and leadership that should be provided by the University, cannot develop as they should. In many respects, in fact, the immediate success or failure of the whole project may depend upon these facilities. I believe the Stander and Blalock reports are so specific concerning this matter that I need not say very much about it, except to emphasize my full agreement with their concept and to point out again how essential it is that the problem be solved promptly. Anyone who has had any teaching experience can take no other point of view.

“As I understand it, at the present time, the University controls no hospital beds at all. No matter how pleasant the arrangements may be informally, and how satisfactory they may seem formally, the position of all clinical departments is weak under such an arrangement.”

I finally accepted the appointment and came to Baylor after Dean Moursund assured me that Hermann Hospital would provide me with a 20-bed surgical service. Although this did not materialize after my arrival here, other factors (fate) played a role in my remaining. Within a few years, however, I became alarmed about a blueprint for the Texas Medical Center that consisted essentially in a “gathering together” in the neighborhood of a number of proposed hospitals and a so-called Central Outpatient Clinic, which was to provide outpatient services for all the hospitals in the center and which was to be administered by the Medical Center Board. This plan was based on the concept that Baylor University College of Medicine would be concerned with undergraduate teaching, and the so-called postgraduate School of Medicine of the University of Texas would assume responsibility for postgraduate instruction, including the residency program. On January 27, 1951, I wrote a memorandum to Judge E.E. Townes, Chairman of the Houston Executive Committee of the Baylor Board of Trustees, in which I reviewed the various aspects of this proposal of the Medical Center and provided a critique of its detrimental impact on Baylor University College of Medicine. I stated: “This is a matter of grave concern both for the Medical Center and for Baylor. Such an eventuality would seal the doom of the Medical Center for a long time – perhaps our lifetime – and it would destroy all hope for the growth and development of Baylor as a strong and vital medical educational institution.” Fortunately, this flawed and ill-advised proposal produced enough strife and dissension to self-destruct.

Our current medical crisis has a historic origin resulting from the complete disregard of the recommendations made in 1948-49 by eminent medical educators, such as Dr. H. H. Stander, Professor of Obstetrics and Gynecology at Cornell University Medical College; Dr. Alfred Blalock of the Johns Hopkins University; and Dr. Basil McLean of the University of Rochester, all of whom were invited as consultants by the Texas Medical Center. All submitted reports embodying similar recommendations for the organization and construction of the Center. All emphasized that a Medical Center consists essentially of a medical school and its affiliated hospital (or hospitals), with complete organizational integration of their personnel and geographic unity of all facilities. They placed great emphasis on those principles, stressing particularly the proper relationship between the medical school and its affiliated teaching hospitals. To quote Dr. Blalock: "By saying hospital facilities, I do not mean mere association or proximity to a hospital where medical students may be permitted to drop in and observe the course of patients, but instead a hospital operated and maintained primarily for the teaching of medical sciences and the investigation of medical problems, and supervised and directed by appropriate members of the medical school faculty just as absolutely as other faculty members are in complete charge of their anatomical dissecting rooms or chemical laboratories."

Of more than passing interest is the following quotation from Dr. H. J. Stander's discussion of the organization of the Center: "Abandonment of complete autonomy on the part of the governing board of each participating hospital. This is absolutely essential, as no first class medical center can be developed by a university board and four or five boards of hospitals acting independently. Again the desired end may be accomplished in more than one way." In this report, he described how this was accomplished by the New York Hospital-Cornell University Medical Center, which originally had two independent boards.

These historical observations would appear on the surface to be incongruous with the apparent subsequent successful development of the Center. But a closer and more incisive analysis of the events of the 50s and 60s, particularly in the defining, momentous autonomy of Baylor College of Medicine in 1969 (including financial support from the State Legislature), along with the eminently successful efforts during the past several decades to upgrade the faculty of the basic science departments to become highly competitive nationally, provides some understanding of the *perception* of successful development. In this connection, it is important to recognize why the basic science departments have achieved great prestige: Baylor had

total authority to search for the best professionals in the country and to provide them with the scientific facilities and environment that would attract and retain them. Baylor does not have such authority for its clinical departments (with perhaps some exception in Pediatrics).

In the 50s through the 70s, we had the good fortune to pioneer a number of highly significant developments in cardiovascular surgery (based largely on laboratory research). These developments were widely acclaimed, bringing patient referrals to us from throughout the world. (I often had 90 to 100 patients in The Methodist Hospital at one time). This provided us with a complete clinical service over which I had both responsibility and authority. Accordingly, I was able to apply the essential academic principles, namely clinical care, teaching, and research. Moreover, this academic service was available to members of other academic clinical departments, since they had responsibilities as consultants to the patients on this service.

In addition, this activity generated broad recognition and attracted higher quality faculty (Dr. William Butler and Dr. Ralph Feigin are examples) and stimulated the expansion in clinical research, including research laboratories in The Methodist Hospital. In the early 1950s I persuaded Mr. Ted Bowen, then Director of The Methodist Hospital, to build the Hospital's first research laboratory on the roof of the hospital; the Fondren-Brown Building for cardiovascular activities was subsequently constructed. Significantly, the architectural plans of the Fondren-Brown building included spaces for research laboratories. Another important factor was the generous financial support we received from the Houston community.

In the meantime, of course, we had obtained affiliations, incorporating academic principles, with the Veterans Administration Hospital and the Jefferson Davis Hospital, which was later moved into the Medical Center (over strong objections from the Harris County Medical Society) and renamed The Ben Taub Hospital. Their significance lies in the fact that they provide the basis for our accredited residency programs. Indeed, without these affiliations Baylor would not be able to obtain an accredited residency program in any specialized field except Pediatrics, which has its own Texas Children's Hospital.

With this succinct historical background, I would like to return to our current crisis. First, it should be observed that we are now in a different medical climate,

perhaps even a different medical *zeitgeist*, than existed during the period just described. For one thing, there are many more medical centers throughout the country with personnel, facilities, and technical capabilities that are reasonably comparable (some of their personnel were trained here). In other words, the playing field is much leveler, and the competition much greater. For another, revenue flow for medical services has become increasingly constrictive. (In the earlier period, I was able to support the financial needs of the Department of Surgery--and even share some of those monies with Baylor generally--entirely from the revenues collected for our clinical surgical services). Today, Medicare payments barely meet, and sometimes fall short of, the actual expenses of providing patient services. Many medical insurers try to follow Medicare's payment policies. This important factor drives the need for greater efficiency in the provision of healthcare.

In order to thrive, and indeed excel, in this changing medical climate, the responsible governance authorities of Baylor and Methodist must jointly address the various factors, forces, and principles of operation that impact these issues. For example, it is not enough to rely on "marketing," as some consultants have advocated. For this purpose, one must first have a superior product, and in the medical field, this usually derives from excellent medical research.

Among the most important guiding principles required in addressing the problems described here and facing both institutions are those concerned with leadership and quality of professionals to meet the challenging forces in this complex, vicissitudinous medical environment. This has already been achieved in Baylor's basic science departments, so I am referring here primarily to the clinical departmental activities at Baylor and The Methodist Hospital. (Incidentally, there is some risk that the high quality of the basic science departments at Baylor could erode if the quality of the clinical departments is not elevated to a comparable level).

The guiding principle referred to above is difficult, if not impossible, to achieve under the current affiliation agreement between Baylor and The Methodist Hospital. This is readily evident from the difficulty we are now experiencing in competing with the best medical institutions in the country for chairmanships of several clinical departments. Even more important, we are now searching for replacements for the executive leadership, the Presidency, of each institution. The competition at this level is even greater and adds emphasis to the need and importance of creating the proper organizational structure and academic environment

between these two institutions to meet the more rigorous national competition at this level. Additionally, and of equal significance, is the fact that the lack of adequate governance of the full-time clinical faculty jeopardizes the quality of medical education of students and residents and of even greater significance may endanger the college's accreditation.

In addition to providing the highest quality of clinical medical activities, these must be performed with optimal efficiency. At the best medical institutions, for example, the Cleveland Clinic, the Mayo Clinic, and the Johns Hopkins Hospital, the completed results of the history, physical findings and laboratory tests, including echocardiography or other ultrasound procedures, CAT scans, MRIs, and the like, as well as the reports of various consultants who see the patients, are all accessible on the computer screen within 24 to 36 hours after the patient is admitted. This is an example of what I mean by efficiency in clinical care. But rarely, if ever, is this possible at The Methodist Hospital and, it would, indeed, be difficult, if not impossible, to accomplish in the current medical organizational structure.

Adding further urgency and significance to this matter are the plans for construction or replacement of new facilities by both Baylor and The Methodist Hospital, most of which require joint responsibility. Although my knowledge of these plans is limited, I enthusiastically support their consideration, for such new facilities are needed and would undoubtedly have a beneficial impact. But here, again, is an example of the crucial need for revising the governance structure of the affiliation agreement between the two institutions to meet the academic principles described above.

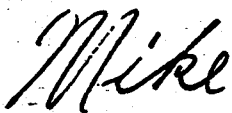
In light of these observations and assessments that now inhibit the pursuit of excellence in the clinical departments, constrain clinical research, impede efficiency in the delivery of medical care, discourage recruitment for the best and most talented professionals for specialized clinical posts and executive leadership, and in view of the proposed plans for needed expansion of clinical facilities, it is now imperative to address and solve the problem underlying these obstacles, which imperil both institutions in the pursuit of excellence. Here, I would suggest reverting to the well-established principles originally enunciated by the eminent visiting consultants to the Texas Medical Center heretofore mentioned.

These principles include, but are not limited to, providing Chairmen/Chiefs with appropriate authority over clinical care, education, and research activities of these representative services at The Methodist Hospital (subject to appropriate accountability) and commensurate with the responsibility expected of them at both the hospital and the medical school; providing appropriate and adjacent research space necessary to develop the application of the most recent advances in molecular biology to patient care; and realignment of monetary support as required under current systems of reimbursement so that revenues across the hospital-medical school system can be applied to appropriate academically based programmatic support and development.

This cannot be done at the clinical and staff levels. Indeed, there is a small, but militant, segment of the staff that would be antipathetic to any changes in the *status quo*. Incidentally, their threat to abandon the Hospital and empty its beds is disingenuous, indeed guileful. In our early affiliation in the 50s, this threat was made when I insisted, successfully, that only qualified surgeons be permitted to perform surgery in The Methodist Hospital. To be sure, some left (because they were not qualified), but the best remained, and it soon became necessary to enlarge the bed capacity.

Since final responsibility and authority reside in the Board of Trustees, it is necessary to address this urgent and crucial problem at that level, and I believe that it can be resolved only at that level. Finally, I am convinced that when all of these historical facts, which are now supported by an additional 50 years of experience in academic medical centers across this nation, are available to the Trustees, they will discharge their responsibilities in the best interests of the institutions.

Respectfully,



Michael E. DeBakey, M.D.

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cc: Dr. Ralph Feigin
Dr. William Butler